

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL HOME OR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2020

CERTIFICATE OF DEATH

Reg. Dist. No. 02009

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY Garrett MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE W. Va. b. COUNTY Marion | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland, | | c. LENGTH OF STAY IN 1b 3 yrs. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont 85 x 3 ✓ |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home | | d. STREET ADDRESS 406 Walnut Ave. | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Margaret Middle Ackerman Last Ackerman | | 4. DATE OF DEATH Month February Day 21 , Year 19 58 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 23, 1870 |
| 9. AGE (In years last birthday) 87 yrs. | | IF UNDER 1 YEAR Months 8 Days 7 Hours 3 Min. | IF UNDER 24 HRS. Months 8 Days 7 Hours 3 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse | | 10b. KIND OF BUSINESS OR INDUSTRY Nursing | 11. BIRTHPLACE (State or foreign country) Cumberland, Md. |
| 13. FATHER'S NAME Joseph Ackerman | | 14. MOTHER'S MAIDEN NAME Barbara Reichert | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. ----- | |
| 17. INFORMANT Weeks Nursing Home | | Address Oakland, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) 8 years | | | INTERVAL BETWEEN ONSET AND DEATH 1 day |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. m. 19 Month, Day, Year p. m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from February 19, 1957 to February 21, 1958 , that I last saw the deceased alive on February 20, 1958 , and that death occurred at 3:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 77 Oak Street, Oakland, Md. DATE SIGNED Feb 22, 1958 ACTUAL SIGNATURE Herbert H. Leighton M.D. PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D. Oakland, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Feb. 24, 1958 | 22c. NAME OF CEMETERY OR CREMATORY S. S. Peter & Paul Cem. | 22d. LOCATION (City, town, or county) (State) Cumberland, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George | | ADDRESS Cumberland, Md. | |
| 24a. REC'D BY REGISTRAR DATE FEB 24 '58 | | 24b. REGISTRAR'S SIGNATURE W. Beach | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02010

Reg. Dist. No.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Garrett</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penna.</u> b. COUNTY <u>Green</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland,</u> | | c. LENGTH OF STAY IN lb <u>4 Mo.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Oak Street "Son's home"</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Lola</u> Middle <u>Grace</u> Last <u>Donley</u> | | 4. DATE OF DEATH Month <u>February</u> Day <u>22</u> , Year <u>19 58</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 1, 1888</u> |
| 9. AGE (In years last birthday) <u>69</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper - Invalid for 8 years</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>West Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Newton Lough</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>---</u> | |
| 17. INFORMANT <u>Daniel Donley</u> | | Address <u>Oakland, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause last. DUE TO (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes mellitus</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>James H. Feaster, Jr.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| ACTING | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DATE SIGNED <u>2-22-58</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>2/25/1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Bald Hill Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Green County, Penna.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. C. Leighton</u> | | 24a. REC'D BY REGISTRAR <u>Feb 24 '58</u> | |
| ADDRESS <u>Oakland, Md.</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. D. Smith</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

32

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02011

| | | | |
|--|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY GARRETT | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Friendsville Md. R.F.D. | |
| c. LENGTH OF STAY IN 1b | | d. STREET ADDRESS Rural | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) WILBUR — KYLE | | 4. DATE OF DEATH 2-8-1958 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept 22 1908 |
| 9. AGE (In years last birthday) 50 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woods Work | | 10b. KIND OF BUSINESS OR INDUSTRY Timber | |
| 11. BIRTHPLACE (State or foreign country) Kva | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME George Kyle | | 14. MOTHER'S MAIDEN NAME Rusty March | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 236-20-4780 | |
| 17. INFORMANT Mrs Wilbur Kyle Friendsville Md | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Immediate | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE James H. Feaster Jr | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) JAMES H. FEASTER JR | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> (ACTING) 2-8-58 | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2-11-1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY Blooming Rose Cem | | 22d. LOCATION (City, town, or county) (State) Friendsville Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.H. Rodakauer - Mackleburg Pa | | 24a. REC'D BY REGISTRAR Feb 13 '58 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE Aut | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
Baltimore, Maryland

BUREAU V. S.

FEB 13 1958

RECEIVED

2023

CERTIFICATE OF DEATH

Reg. Dist. No.

02012

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY GRANT | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. STORM WVA. RT. 42 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL | | d. STREET ADDRESS 85X-3 | |
| 3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last LAMBKA | | 4. DATE OF DEATH Month FEBRUARY Day 19 Year 1958 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/10/58 |
| 9. AGE (In years last birthday) yrs. 10 | | IF UNDER 1 YEAR Months 10 Days 18 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) MT. STORM, W. VA. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME WILLIAM LAMBKA | | 14. MOTHER'S MAIDEN NAME HELEN ELAINE HANLIN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT MRS. LOYAL MORELAND, (COUSIN) | | Address MT. STORM, W. VA. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY 776X DUE TO (6 mos gestation - wt 2 lbs 10 oz) Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) 10 days (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from 2-11 , 19 58 , to 2-19 , 19 58 , that I last saw the deceased alive on 2-19-58 , 19 58 , and that death occurred at 10:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 58 2-19-58 | | | |
| ACTUAL SIGNATURE [Signature] M.D. 58 2-19-58 | | | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF FEB-21-1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY IDLEMAN CEMETERY | | 22d. LOCATION (City, town, or county) (State) NEAR MT. STORM, WVA. RT. 42 | |
| 23. FUNERAL DIRECTOR'S SIGNATURE [Signature] | | ADDRESS OAKLAND, MS | |
| 24a. REC'D BY REGISTRAR [Signature] | | 24b. REGISTRAR'S SIGNATURE [Signature] | |
| DATE FEB 24 '58 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

| | |
|----------------------------|--|
| 1. NAME OF DECEASED | |
| 2. SEX | |
| 3. AGE | |
| 4. DATE OF BIRTH | |
| 5. PLACE OF BIRTH | |
| 6. OCCUPATION | |
| 7. CAUSE OF DEATH | |
| 8. PLACE OF DEATH | |
| 9. TIME OF DEATH | |
| 10. SIGNATURE OF PHYSICIAN | |
| 11. SIGNATURE OF REGISTRAR | |

BOND

BUREAU V. 81

FEB 24 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2024

CERTIFICATE OF DEATH

Reg. Dist. No. 02013

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL | | | | d. STREET ADDRESS #9 ALDER ST. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First ANNIE Middle TREACY Last PENDERGAST | | | | 4. DATE OF DEATH Month FEBRUARY Day 25 Year 1958 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH MAY 18, 1873 | |
| 9. AGE (In years last birthday) 84 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME JAMES TREACY | | | | 14. MOTHER'S MAIDEN NAME BRIDGET BOYLE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 216-18-1747 | | 17. INFORMANT MRS. HELEN BAUMGARTNER Address OAKLAND MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, abdominal, origin metastatic, 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 3 years | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from 1-4 , 19 58 , to 2-25 , 19 58 , that I last saw the deceased alive on 2-24 , 19 58 , and that death occurred at 6:00 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Joseph Alvarez | | | | DATE SIGNED Oakland, Md. Feb. 25, 1958 | | | |
| PHYSICIAN'S NAME (Type) Joseph Alvarez | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF FEB-27-1958 | | 22c. NAME OF CEMETERY OR CREMATORY OAKLAND CEMETERY | | 22d. LOCATION (City, town, or county) (State) OAKLAND MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Balton Funeral Home | | | | 24a. REC'D BY REGISTRAR DEAR 4 '58 | | 24b. REGISTRAR'S SIGNATURE Dee Deane | |

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2025

Reg. Dist. No. 02015

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Garrett MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Garrett | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Swanton-rural | | | | c. LENGTH OF STAY IN 1b Swanton-Rural | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5 Mi E. of Swanton | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Arnie Alvin Rhodes | | | | 4. DATE OF DEATH Feb. 20 1988 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 8, 1884 | |
| 9. AGE (In years last birthday) 74 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner | | | | 10b. KIND OF BUSINESS OR INDUSTRY Coal Mine | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Andrew J. Rhodes | | | | 14. MOTHER'S MAIDEN NAME Emily Bray | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. no | | 17. INFORMANT Charles Rhodes-R.D. Swanton, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE James W. Fenster Jr. M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) J. H. Fenster Jr. M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Acting | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Feb. 22, 58 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Zion | | 22d. LOCATION (City, town, or county) (State) Garrett County, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE E. B. Bual ADDRESS Westernport, Md. | | | | 24a. REC'D BY REGISTRAR FEB 24 '58 | | 24b. REGISTRAR'S SIGNATURE Dee | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

FEB 24 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2026

CERTIFICATE OF DEATH

02016

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE W.VA. b. COUNTY GRANT. ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BAYARD W.VA. 85X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 99 DIED ON ARRIVAL TO HOSPITAL | | | | d. STREET ADDRESS BAYARD | | | |
| 3. NAME OF DECEASED (Type or print) First BETTY Middle Jo Last Roy | | | | 4. DATE OF DEATH Month FEB - Day 21 Year 1958 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH SEPT. 29 - 1937 | |
| 9. AGE (In years last birthday) 20 yrs. | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HRS. Hours _____ Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS | | | | 10b. KIND OF BUSINESS OR INDUSTRY TABLE ROCK GARRETT CO | | | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME HOWARD Roy | | | | 14. MOTHER'S MAIDEN NAME NINA PENNINGTON | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 224-62-286 | | 17. INFORMANT Address MRS NINA Roy BAYARD W.VA. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 473x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tonillitis, severe DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Vomiting resulting in dehydration INTERVAL BETWEEN ONSET AND DEATH 36 hours 3 days | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____ | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from June 1, 1957 , to February 21, 1958 , that I last saw the deceased alive on February 19, 1958 , and that death occurred at 12 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 77 Oak St., Oakland, Md. DATE SIGNED FEB 22 1958 ACTUAL SIGNATURE Robert H. Leighton M.D. PHYSICIAN'S NAME (Type) Dr. Herbert H. Leighton Oakland, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF FEB-24-1958 | | 22c. NAME OF CEMETERY OR CREMATORY BAYARD CEMETERY | | 22d. LOCATION (City, town, or county) (State) BAYARD W.VA. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Golden Funeral Home, Oakland, Maryland | | | | 24a. REC'D BY REGISTRAR DATE FEB 26 '58 | | 24b. REGISTRAR'S SIGNATURE Alfred Smith | |

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|--|--|--------------------------------------|--|---------------------------------------|--|
| NAME OF DECEASED [Faint text] | | AGE [Faint text] | | SEX [Faint text] | | RACE [Faint text] | |
| DATE OF DEATH [Faint text] | | PLACE OF DEATH [Faint text] | | CITY [Faint text] | | COUNTY [Faint text] | |
| CAUSE OF DEATH [Faint text] | | MANNER OF DEATH [Faint text] | | OCCUPATION [Faint text] | | EDUCATION [Faint text] | |
| DISEASE OR INJURY [Faint text] | | IMMEDIATE CAUSE [Faint text] | | INTERMEDIATE CAUSE [Faint text] | | FUNDAMENTAL CAUSE [Faint text] | |
| SIGNATURE OF PHYSICIAN [Faint text] | | SIGNATURE OF REGISTRAR [Faint text] | | SIGNATURE OF WITNESS [Faint text] | | SIGNATURE OF DECEASED [Faint text] | |
| DATE OF SIGNATURE [Faint text] | | DATE OF SIGNATURE [Faint text] | | DATE OF SIGNATURE [Faint text] | | DATE OF SIGNATURE [Faint text] | |

BUREAU V. S.
FEB 26 1938

RECEIVED

RECEIVED

2027

CERTIFICATE OF DEATH

02017

Reg. Dist. No.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Oakland</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Oakland,</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2 Mi. S. Oakland, Route 219</u> | | d. STREET ADDRESS <u>2 Mi. S. Oakland, Route 219</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Harry Sanders</u> | | 4. DATE OF DEATH Month Day Year <u>February 27, 19 58</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>May 20, 1874</u> |
| 9. AGE (In years last birthday) <u>83</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Henry G. Sanders</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Moon</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>219 01 7801</u> | |
| 17. INFORMANT <u>George Sanders, R. D. Oakland, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>1.5 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>February 25, 19 58</u> to <u>February 27, 19 58</u> , that I last saw the deceased alive on <u>February 25, 19 58</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>77 Oak Street, Oakland, Md.</u> <u>2/28/58</u> | | | |
| ACTUAL SIGNATURE <u>Herbert H. Leighton</u> M.D. | | PHYSICIAN'S NAME (Type) <u>Herbert H. Leighton, M. D.</u> <u>Oakland, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>3/2/1958</u> | <u>Red House Cemetery</u> | <u>Garrett Co., Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Leighton</u> | | ADDRESS <u>Oakland, Md.</u> | 24a. REC'D BY REGISTRAR DATE <u>MAR 5 '58</u> |
| | | 24b. REGISTRAR'S SIGNATURE <u>W. Search</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME OR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2028

CERTIFICATE OF DEATH

02018

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Garrett MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Preston | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland | | c. LENGTH OF STAY IN 1b 21 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital | | d. STREET ADDRESS 110 Lakin Avenue | |
| 3. NAME OF DECEASED (Type or print) First Arthur Middle Bower Last Schwer | | 4. DATE OF DEATH Month February Day 17 Year 1958 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 3, 1885 |
| 9. AGE (In years last birthday) 72 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millwright | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Verona, Pa. | | 12. CITIZEN OF WHAT COUNTRY? America | |
| 13. FATHER'S NAME William Franklin Schwer | | 14. MOTHER'S MAIDEN NAME Lena Bower Schwer | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 232-22-0379A | |
| 17. INFORMANT "Wife" Vivian Dorothy Schwer | | Address 110 Lakin Ave. Terra Alta, W. Va. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus 612x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Thrombo phlebitis, rt. leg. DUE TO (c) Prostate operation. | | INTERVAL BETWEEN ONSET AND DEATH Minutes Several days. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1-27-58 , 1958, to 2-17-58 , 1958, that I last saw the deceased alive on 2-17-58 , 1958, and that death occurred at 2:25 A. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Joseph Alvarez M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED Oakland, Md. 2/17/58 | |
| PHYSICIAN'S NAME (Type) Joseph Alvarez, M. D. | | Oakland, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial | | 22b. DATE THEREOF 2-20-1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY Terra Alta Cemetery | | 22d. LOCATION (City, town, or county) (State) Terra Alta, West Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William ADDRESS Terra Alta, W. Va. | | 24a. REC'D BY REGISTRAR DATE FEB 20 1958 | |
| 24b. REGISTRAR'S SIGNATURE W. H. H. H. | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. S.

FEB 20 1953

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G226 3-10-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

02019

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND | | c. LENGTH OF STAY IN 1b 2 1/2 DAYS | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (BLAINE) KITZMILLER, MARYLAND | | 85X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL | | d. STREET ADDRESS (Res. Blaine, W. Va., P.O. Kitzmiller) | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First OTHA Middle FRANCIS Last SHARPLESS | | 4. DATE OF DEATH Month FEBRUARY Day 26, Year 1958 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH FEB. 4, 1879 |
| 9. AGE (In years last birthday) 79 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FUNERAL DIRECTOR | | 10b. KIND OF BUSINESS OR INDUSTRY UNDERTAKING | |
| 11. BIRTHPLACE (State or foreign country) WEST VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME SHARPLESS, BENJAMIN | | 14. MOTHER'S MAIDEN NAME PAUGH, AMY | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 215 36 9791 | |
| 17. INFORMANT AMY MILDRED SHARPLESS, KITZMILLER, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic C.V.D. DUE TO (c) Sudden Interval between onset and death 8 years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2/23/58 , 19____, to 2-26-58 , 19____, that I last saw the deceased alive on Feb. 26, 19 58 , and that death occurred at 3:00 a.m. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE A. E. Mance M.D. | | DATE SIGNED 26 Feb 58 | |
| PHYSICIAN'S NAME (Type) A. E. MANCE, M.D. | | OAKLAND, MARYLAND | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/1/1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY I. O. O. F. Cemetery | | 22d. LOCATION (City, town, or county) (State) Elk Garden, W. Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE A. C. Leighton | | ADDRESS Oakland, Md. | |
| 24a. REC'D BY REGISTRAR DATE MAR 5 '58 | | 24b. REGISTRAR'S SIGNATURE W. Leach | |

RECEIVED

2030

CERTIFICATE OF DEATH

Reg. Dist. No.

02020

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY TUCKER | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND | | | | c. LENGTH OF STAY IN 1b 25 DAYS | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DAVIS | | | | d. STREET ADDRESS BOX 263 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First MARY Middle HAZEL Last SOWERS | | | | 4. DATE OF DEATH Month FEBRUARY Day 1 Year 1958 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8-18-13 | |
| 9. AGE (In years last birthday) 44 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) WEST VIRGINIA | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME WILLIAM MILLER | | | | 14. MOTHER'S MAIDEN NAME PEARL LEE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Non (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT HARRY SOWERS, BOX 263, DAVIS, W. VA. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 203x IMMEDIATE CAUSE (a) Multiple Myeloma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 years | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Oakland, Md. | | | | 20g. (County) Garrett | | 20h. (State) Md. | |
| 21. I certify that I attended the deceased from November 15, 1957 to February 1, 1958 , that I last saw the deceased alive on January 31, 1958 , and that death occurred at 6:05 a.m. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Herbert H. Leighton M.D. | | | | ADDRESS (Street, city or town, state) 77 Oak St. Oakland, Md. | | | |
| DATE SIGNED Feb. 1, 1958 | | | | | | | |
| PHYSICIAN'S NAME (Type) HERBERT LEIGHTON, M.D. | | | | OAKLAND, MARYLAND | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/4/58 | | 22c. NAME OF CEMETERY OR CREMATORY Rose Hill | | 22d. LOCATION (City, town, or county) (State) Thomas W. Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. H. Duncan | | | | ADDRESS Thomas, W. Va. | | 24a. REC'D BY REGISTRAR FEB 6 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE W. H. Search | | | |

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Faint text, possibly "JOHN DOE"]

2. SEX: [Faint text, possibly "Male"]

3. AGE: [Faint text, possibly "45 years"]

4. DATE OF BIRTH: [Faint text, possibly "1910-01-15"]

5. PLACE OF BIRTH: [Faint text, possibly "Baltimore, Maryland"]

6. OCCUPATION: [Faint text, possibly "Teacher"]

7. CAUSE OF DEATH: [Faint text, possibly "Heart Disease"]

8. DATE OF DEATH: [Faint text, possibly "1958-06-10"]

9. PLACE OF DEATH: [Faint text, possibly "Home"]

10. SIGNATURE OF PHYSICIAN: [Faint signature]

11. SIGNATURE OF REGISTRAR: [Faint signature]

12. SIGNATURE OF WITNESS: [Faint signature]

BUREAU FILE

RECEIVED

13 6 1958

2031

CERTIFICATE OF DEATH

Reg. Dist. No. 02021

| | | | | | | | |
|--|----------------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Garrett MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hutton | | | | c. LENGTH OF STAY IN 1b 4 yrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION --- | | | | d. STREET ADDRESS --- | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Sidney Middle Jacob Last Spiker | | | | 4. DATE OF DEATH Month February Day 12 Year 19 58 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 10, 1872 | 9. AGE (In years lost birthday) 85 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sawyer of Lumber | | 10b. KIND OF BUSINESS OR INDUSTRY on saw mill | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas Spiker | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Jane Lewis | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 232 03 2655-A | | 17. INFORMANT Address Mava Spiker Mt. Lake Park, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Brucella pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) 10 yrs | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5 Feb , 19 58 , to 12 Feb , 19 58 , that I last saw the deceased alive on 10 Feb , 19 58 , and that death occurred at 9:10A M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Andrew E. Mance M.D. | | | | ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED 13 Feb 58 | | | |
| PHYSICIAN'S NAME (Type) Andrew E. Mance, M. D. | | | | Oakland, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/14/1958 | | 22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery | | 22d. LOCATION (City, town, or county) (State) Oakland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton | | | | ADDRESS Oakland, Md. | | 24a. REC'D BY REGISTRAR DATE FEB 18 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE W. F. Smith | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME OR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2032

CERTIFICATE OF DEATH

02022

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|----------------------------------|
| 1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRELLIN | | | | c. LENGTH OF STAY IN 1b MD | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First REBECCA Middle JANE Last STILES | | | | 4. DATE OF DEATH Month FEB Day 4 Year 1958 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH JUNE-3-1878 | |
| 9. AGE (In years last birthday) 79 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY WANA W.VA. | | 11. BIRTHPLACE (State or foreign country) U.S.A. | |
| 13. FATHER'S NAME LEVI STILES | | | | 14. MOTHER'S MAIDEN NAME ELIZABETH SENTIE. | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT WILLIAM R. STILES Address GRELLIN MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PARKINSON'S DISEASE 350 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Nov , 1954, to Feb , 1958, that I last saw the deceased alive on Nov 27 , 1957, and that death occurred at 10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE E. J. BAUMGARTNER M.D. AS ADLER ST 2/5/58 PHYSICIAN'S NAME (Type) E. J. BAUMGARTNER OAKLAND | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF FEB-6-1958 | | 22c. NAME OF CEMETERY OR CREMATORY UNDERWOOD CEMETERY NEAR OAKLAND MD. | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Helen E. L. Home Funeral Director | | | | 24a. REC'D BY REGISTRAR DATE FEB 11 '58 | | 24b. REGISTRAR'S SIGNATURE Rebecca | |

MEDICAL CERTIFICATION

TO HOSPITAL: The attending physician: The low requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FEB 11 1958

BUREAU V. 8

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2033

CERTIFICATE OF DEATH

Reg. Dist. No. 42028

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH o. COUNTY Garrett MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland. b. COUNTY Garrett | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland | | c. LENGTH OF STAY IN 1b 70 yrs. | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Oakland, | | d. STREET ADDRESS 12 Mi. N. Oakland, Md. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Thayne Middle Oliver Last White | | 4. DATE OF DEATH Month February Day 5 Year 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 3, 1888 |
| 9. AGE (In years last birthday) 70 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) Farmer and Janitor | | 10b. KIND OF BUSINESS OR INDUSTRY Court House | |
| 11. BIRTHPLACE (State or foreign country) Maryland. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James W. White | | 14. MOTHER'S MAIDEN NAME Flora McCrum | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. -- | |
| 17. INFORMANT Mrs. Thayne O. White | | Address Oakland, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 7 years | | INTERVAL BETWEEN ONSET AND DEATH 5 minutes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Glomerular Nephritis | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. m. Month, Day, Year p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from February , 19 57 , to February , 19 58 , that I last saw the deceased alive on January 30 , 19 58 , and that death occurred at 7:45A M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Herbert H. Leighton | | ADDRESS (Street, city or town, state) 77 Oak St. Oakland, Md. | |
| PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D. | | DATE SIGNED 6 Feb. 58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/7/1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery | | 22d. LOCATION (City, town, or county) (State) Oakland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton | | ADDRESS Oakland, Md. | |
| 24a. RECEIVED BY REGISTRAR FEB 10 1958 | | 24b. REGISTRAR'S SIGNATURE W. L. Smith | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1958 10 FEB

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